



# State of New Hampshire

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## Infants in the Workplace Program

### CARE PROVIDER AGREEMENT

**About this form:** This form is used by an employee who has been selected at work as a care provider for the infant of another employee while at work. Human Resources will complete the **REVIEW** section.

- Care Provider: Complete and sign this form and return to the Parent.
- Parent: Submit this form to your HR Office, along with the Application and Waiver of Liability form.

#### CARE PROVIDER

As a Care Provider, I understand and agree to the following:

- When necessary, I will provide care for \_\_\_\_\_ (“Infant”) when (“Parent”) is unavailable.
- I will move to Parent’s workstation, or the infant will be brought to my workstation, whichever is most convenient.
- I understand my role as a care provider does not relieve me of my responsibilities as a employed by the State of New Hampshire.
- I understand that I am not to provide care for an infant for more than one (1) hour within my daily scheduled work hours. I understand that my role as a care provider cannot result in overtime or compensatory time.
- I understand there may be another designated care provider \_\_\_\_\_, with these same duties who I may contact if I require assistance.
- I will be notified by Parent if there is any change in Care Providers under this agreement.
- No Persons will be responsible for the baby except for Parent, Other Care Provider, and me.
- I will not release the infant under my care to any individual other than Parent or Other Care Provider.
- If at any time I no longer agree to act as Care Provider for Infant, I shall give written notice to Parent.
- I understand that if I am a probationary employee or under a Performance Improvement Plan, I may not be eligible to participate in this program as a Care Provider.
- I understand that I may not be a Care Provider as a subordinate employee to the Parent.

The undersigned hereby agrees to act as a Care Provider as described above. I acknowledge that I have read and understand the terms of this Care Provider Agreement as set forth above.			
<b>Employee Signature:</b>		<b>Date:</b>	
<b>REVIEW</b>			
<b>Supervisor/Administrator Signature:</b>	<b>Date:</b>	Recommended	Not recommended*
<b>Human Resources Signature:</b>	<b>Date:</b>	Approved	Denied*
<b>*Reason for Denial:</b>			
Safety Concern	Performance Issue	Other (specify below):	